AlphaOmegaFood.com

Confidential Health Questionnaire

NAME ____
ADDRESS ____
CITY________________________STATE ___________ ZIP __________
PHONE: Area Code _____ Home No.___________ Work No.______________
Date of Birth__________ Age ______Sex ______ Height ____ Weight ________
Occupaton:
____

LIST YOUR MAIN HEALTH CONCERNS
State briefly how long each has bothered you.

____
____
____
____
____

Answer the following questions either with an “X”, a quantity, and/or by underlining where they pertain to you. Make any additional comments you wish in the space provided below each section.

THESE QUESTIONS REFER TO CURRENT CONDITIONS except where otherwise indicated.

Head

- ☐ frequent or regular headaches; how often? ______________________
  (state below where you feel the headache)
- ☐ headache occurs upon rising
- ☐ headache occurs later in the day
- ☐ headache all the time (when present)
- ☐ headaches associated with any food, drug, stress or activity
- ☐ headache associated with neck ache
- ☐ headache associated with sinus or hay fever or allergies
- ☐ migraine headaches

What makes your headache better (cold, lying down, standing, etc.)?
What makes your headache worse (heat, light, noise, standing, etc.)?
List any additional problems.

____
____
____

SINUSES

- ☐ sinus congestion
- ☐ sinus drainage
- ☐ sinus infections
- ☐ hay fever, if so ☐ all the time, or ☐ seasonal
- ☐ frequent colds

List any additional problems.

____

____

EYES

- ☐ burning eyes
- ☐ itching eyes
- ☐ eye infections
- ☐ blurred vision
- ☐ diminishing vision
- ☐ blood shot eyes
- ☐ yellow sclera (whites of eyes)
- ☐ eyes sensitive to light such as sunlight or headlights

List any additional problems.

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EARS

- ☐ ringing or buzzing sounds
- ☐ any discharge
- ☐ chronic infections
- ☐ hearing loss

List any additional problems.

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THROAT

- ☐ frequent sore throats
- ☐ tonsillitis

List any additional problems.

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CARDIOVASCULAR (Heart/Lungs/Blood System)

☐ heart attack(s); when? ____

☐ stroke(s); when? ____

(List below any resulting consequences, paralysis, etc.)

☐ heart does flip-flops or skips a beat from time to time

☐ blood pressure problems

☐ arteriosclerosis (plaque inside arteries)

☐ bronchitis

☐ asthma

☐ cough up phlegm in mornings

☐ chronic congestion (cough)

☐ frequent chest colds

☐ pneumonia

☐ emphysema

☐ chest pain

☐ bruise easily

☐ varicose veins

☐ anemia (low iron/red blood cells)

☐ leukemia

☐ shortness of breath

☐ work or live in a polluted air environment

☐ do you smoke (cigarettes, pipe, cigars); how many per day?________

List any additional problems.

____

____

DIGESTION and **COLON**

☐ indigestion most of the time

☐ indigestion some of the time or only with certain foods

☐ heartburn

☐ belching

☐ bloating

☐ lower bowel gas

☐ ulcers (past or present)

☐ any stomach or intestinal pain

☐ drink some alcohol; how much per week? ___________________

☐ drink coffee/hot tea; how many cups per day? ___________________

☐ drink iced tea; how many glasses per day?________________________

☐ drink soft drinks; how many can/bottles per day? ______________________

What type of water to you drink?

☐ distilled/reverse osmosis filtered

☐ tap

☐ spring/mineral/well

how much water to you drink per day?____

☐ chewing tobacco/dip/snuff

☐ non-prescription drugs on a regular basis? What?___________________________________

Do you have a strong craving for:

- ☐ salt (or salty foods)
- ☐ chocolate
- ☐ starchy foods
- ☐ sugar (candy, pastries, etc.)
- ☐ alcohol
- ☐ meat
- ☐ spicy foods
- ☐ soft drinks

List any other food or drink for which you have a strong craving.
____

- ☐ irritable, shaky, weak, or headachy if late for or miss a meal
- ☐ constipation problems: how long? ______________________________________
- ☐ use a laxative or bulk former to have bowel movements
- ☐ diarrhea on regular basis
- ☐ constipation alternating with diarrhea
- ☐ indicate how often you have a bowel movement ____________________________
- ☐ hemorrhoids

Have you been diagnosed with:

- ☐ Ulcerative Colitis
- ☐ Colitis
- ☐ Diverticulitis
- ☐ Chron's Disease

List any additional problems.
____
____

MUSCULOSKELETAL (muscles, joints, bones, spine and extremities)

General

- ☐ spinal arthritis
- ☐ rheumatoid or osteoarthritis
- ☐ osteoporosis (loss of mineral of bones)
- ☐ joint aches/pain (state where, below)
- ☐ muscle weakness (constant)
- ☐ muscle weakness upon rising, better as day wears on
- ☐ muscle atrophy; state where: ____

Neck

- ☐ stiff (limited or restricted range of motion)
- ☐ ache
- ☐ pain
- ☐ worse upon rising
- ☐ worse in evening
- ☐ worse with tension and stress
- ☐ ever had whiplash accident: when? ______________________________________

Mid Back

- ☐ Sharp pain, worse with deep breath or movement
- ☐ Ache

Low Back

- ☐ pain
- ☐ ache
- ☐ stiff
- ☐ worse upon rising
- ☐ worse in evening
- ☐ worse with activity
- ☐ hurt in past (explain below)
- ☐ hip and/or sciatic pain

List any additional problems.

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Upper Extremity

- ☐ shoulder pain, L/R, how long? ______________________________________
- ☐ arm problems
- ☐ hand problems (numbness, pain, tingling)
- ☐ cold hands

Lower Extremity

- ☐ pain radiating from low back or hip down leg
- ☐ thigh problems
- ☐ knee problems
- ☐ leg cramps (while working/after resting)
- ☐ leg problems
- ☐ feet problems
- ☐ cold feet
- ☐ burning feet
- ☐ foot odor

List additional problems.

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SKIN

Do you currently have skin problems including:

- ☐ too dry
- ☐ too oily
- ☐ re-occurring rash
- ☐ acne
- ☐ boils

- ☐ psoriasis
- ☐ eczema
- ☐ dandruff
- ☐ skin allergies; specify: ____
- ☐ body odor
- ☐ hair loss
- ☐ do you use medicated shampoo
- ☐ do you use skin/body lotions on a regular basis
- ☐ do you use an antiperspirant deodorant

List any additional problems.

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FEMALE

Menstrual Cycle

- ☐ irregular
- ☐ heavy flow/clotting
- ☐ cramps (hard/medium/light)
- ☐ retain fluid in association with period
- ☐ emotional distress in association with period (PMS)
- ☐ breast swelling/lumps/tenderness in association with period

Breast

- ☐ chronic or constant lumps/tenderness
- ☐ nipple discharge
- ☐ mastectomy L/R; when: ____
- ☐ cosmetic breast surgery; specify: ____________________________________

Menopause

- ☐ having symptoms (hot flashes, etc.)
- ☐ past (at what age?) ________

Pregnancies

How many full term, live-birth pregnancies: ___________________________________

- ☐ miscarriages; how many? __________________
- ☐ caesarean sections
- ☐ difficult deliveries
- ☐ unable to conceive

Surgeries

hysterectomy (uterus only/complete); when and why? _______________________

- ☐ D&C; when and why? ____
- ☐ 'tubes tied' (tubal ligation); when? ____________________________________
- ☐ other related surgeries (state below)

General

- ☐ sex drive diminished or absent
- ☐ take birth control pills; how long? _____________________________________
- ☐ frequent bladder/kidney/vaginal infections

List any additional problems.

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MALE

☐ sexual drive diminished or absent
☐ impotence

Prostate

☐ prostate problems
☐ difficulty urinating/starting
☐ frequency
☐ frequent trips to rest room at night; how many? ___________________
☐ burning upon urination
☐ incomplete emptying

List any additional problems.

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____
____

KIDNEY & BLADDER

☐ frequent kidney or bladder infections
☐ kidney stones (past/present)
☐ dialysis; how long?

List any additional problems.

____
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____

GLANDULAR SYSTEM

Do you have any problems with:

☐ spleen; if so explain below
☐ pancreas; if so explain below
☐ adresnal; if so explain below
☐ pituitary; if so explain below
☐ thyroid; if so explain below
☐ liver; if so explain below
☐ gal bladder; if so explain below

Other ____

Diabetes; how long? ___________________________________

Diabetes controlled with:

☐ diet only
☐ oral insulin; what and how much?______________________________________
☐ injectable insulin; how many units daily?_________________________________

☐ hypoglycemia
☐ allergies; specify: ____

List any additional problems.

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NERVOUS SYSTEM

- ☐ epilepsy
- ☐ dyslexia
- ☐ attention deficit disorder
- ☐ any other diseases or disorders of the nerves or brain

List any additional problems.

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WEIGHT

- ☐ overweight; how much? __________________________; how long? ____________________
- ☐ underweight; how much? __________________________; how long? ____________________
- ☐ weight fluctuates abnormally

List any additional problems.

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SLEEP

- ☐ difficulty falling asleep
- ☐ difficulty staying asleep
- ☐ restless sleeper
- ☐ frequent nightmares
- ☐ wake up in night feeling hungry
- how many trips to rest room at night? __________________________

Sleep mainly on:

- ☐ back
- ☐ side
- ☐ stomach

Mattress:

- ☐ water bed
- ☐ hard
- ☐ medium
- soft

List any additional problems.

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ENERGY LEVEL

Rate your average energy level:

- ☐ high
- ☐ fine
- ☐ low

- ☐ wake up tired
- ☐ have mid-morning energy slump
- ☐ have mid-afternoon energy slump
- ☐ extremely tired by evening
- ☐ tired all the time
- ☐ sleepy after a big meal

List any additional problems.

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EMOTIONAL/MENTAL

- ☐ emotionally even-keeled
- ☐ moody
- ☐ irritable
- ☐ frequent depression
- ☐ memory loss/poor memory
- ☐ loss of concentration ability
- ☐ thinking ability ‘cloudy’
- ☐ mental illness in past

List any additional problems.

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CHILDHOOD DISEASES

- ☐ measles
- ☐ mumps
- ☐ chicken pox
- ☐ polio
- ☐ chronic ear infections
- ☐ frequent colds/flu’s
- ☐ allergies (that you have outgrown)
- ☐ other ____

____

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ACCIDENTS & INJURIES

List any accidents or injuries of major consequences. State when occurred.

____

____

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SURGERIES
List all surgeries you have had and the approximate date (don't forget to include tonsillectomy and appendectomy). [NOTE: No need to re-list any surgeries you've already listed elsewhere on this questionnaire.]

Date	*Surgery*

GENERAL

- ☐ Currently under treatment elsewhere for a specific health problem?
  If so, list the problem and the treatment being used. ______

List any major disease(s) you have been diagnosed and treated for which you have not already listed. List what treatment was administered.

List any inherited or congenital malformations or deformities.

- ☐ do you own a juicer; what brand?
- ☐ do you own a mini-trampoline?
- ☐ do you exercise; state what type and how often: ______

MEDICATIONS
List all medications you are taking on a regular basis. State for what reason the medication was prescribed. Include any non-prescription drugs like aspirin, laxatives, antacids, etc.

SUPPLEMENTS

List any 'natural' supplements you are currently taking. Include all vitamin, mineral, glandular, herb, homeopathic, etc. preparations. Brand names would be helpful, but not necessary. It is **not** necessary to list dosages or milligrams, etc.

DIET

List below your **average** intake (food, liquids, snacks, cigarettes, etc.) for three (3) days.

BREAKFAST

LUNCH

SUPPER